MEDRX

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Notice of Independent Review Decision

DATE OF REVIEW: 4/12/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of L5-S1 laminectomy neuroplast, Dura, nerve roots and spinal monitoring, Inpatient stay x3

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the L5-S1 laminectomy neuroplasty, Dura, nerve roots and spinal monitoring, Inpatient stay x3

PATIENT CLINICAL HISTORY [SUMMARY]:

The xx-year-old is noted to be s/p revision of L2-3 nonunion of spinal fusion. Clinical records reviewed most recently revealed persistently severe back pain including while in physical therapy. An electrical study from January 18, 2013 involving the then xx-year-old and the lower extremities was noted to reveal no evidence of radiculopathy. He underwent a CT myelogram on November 20, 2014. There was a questionable fusion noted at the L2-3 level. There was a prior fusion evident at L5-S1. Disc bulges were noted at L3-4 and L4-5. The

others spinal levels were noted to be unremarkable. The 12-18-14 dated clinical exam findings included a history of “back and leg/groin pain.” There were lumbar surgical scars with tenderness of the paraspinal muscles. Throughout the lower extremities there was no grade 5/5 motor power. Sensation in the right leg was noted to be “decreased.” Reflexes in the lower extremities were noted to be 3/3. Straight leg raise test was negative bilaterally. The assessment included database status post-surgical intervention including MIS PLIF/TLIF at L2-3 revised to TLIF at L2-3 with improved leg and foot symptomatology along with severe back pain. The plan was to continue therapy and exercises along with medications. An addendum to the clinical note of December 18, 2014 discussed the CT myelogram of November 20, 2014. There was noted to be a large right-sided disc herniation at L5-S 1 that could represent either scar tissue and/or retained disk fragments. Therefore surgical intervention was felt indicated at that level. Denial letters indicated that there were no significant and recent abnormal neurologic findings on examination correlating with imaging (as reported by the AP.) There was also noted to be a discrepancy in the CT myelogram and report from the radiologist versus the report from the treating provider. There was also noted to be “limited evidence for recurrent nerve root compromise at L5-S 1 due to disc pathology.” A letter from the treating provider dated February 2, 2015 discussed that the radiologist had provided an addendum indicating “there is some soft tissue density in the epidural space on the right indicative of granulation tissue.” The provider indicated that the combination of the addendum contents and the clinical history of radiculopathy supports the proposed surgery as per guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Clinical and imaging do not provide significantly evidence of radiculopathy. Neurological findings in the lower extremities were unremarkable. Also nonspecific findings at L5-S1 did not detail evidence of nerve root compression; the over requests do not meet the guideline criteria referenced below.

ODG Indications for Surgery -- Discectomy/Laminectomy
Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.
L5 nerve root compression, requiring ONE of the following:
1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy

2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness

3. Unilateral buttock/posterior thigh/calf pain (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (L3, L4, L5, or S1)

B. Lateral disc rupture

C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging

2. CT scanning

3. Myelography

4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= 2 months)

B. Drug therapy, requiring at least ONE of the following:

1. NSAID drug therapy

2. Other analgesic therapy

3. Muscle relaxants

4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. Physical therapy (teach home exercise/stretching) 2. Manual therapy (chiropractor or massage therapist) 3. Psychological screening that could affect surgical outcome 4. Back school (Fisher, 2004)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**